

		FOR OHF USE					

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0015032

Facility Name: WASHINGTON AND JANE SMITH

Address: 2340 W 113TH PLACE CHICAGO 60643

County: COOK

Telephone Number: (773) 779-8010 Fax # (773) 779-8648

IDPA ID Number: 362167948001

Date of Initial License for Current Owners:

Type of Ownership:

X

VOLUNTARY,NON-PROFIT

X

Charitable Corp.

Trust

IRS Exemption Code

PROPRIETARY

Individual

Partnership

Corporation

"Sub-S" Corp.

Limited Liability Co.

Trust

Other

GOVERNMENTAL

State

County

Other

In the event there are further questions about this report, please contact:
Name:: Steve Lavenda Telephone Number: (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/01 to 06/30/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed)

(Type or Print Name)

(Title)

Paid Preparer

(Signed) See Accountants' Compilation Report Attached

(Print Name and Title)

(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C. 111 Pfingsten Road, Suite 300 Deerfield, IL 60015

(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WASHINGTON AND JANE SMITH

0015032 Report Period Beginning: 07/01/01 Ending: 06/30/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	94	Skilled (SNF)	94	34,310	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	185	Sheltered Care (SC)	185	67,525	5
6		ICF/DD 16 or Less			6
7	279	TOTALS	279	101,835	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	10,557	20,530	1,493	32,580	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC	5,737	41,732	280	47,749	12
13	DD 16 OR LESS					13
14	TOTALS	16,294	62,262	1,773	80,329	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.88%

SEE ACCOUNTANTS' COMPILATION REPORT

D. How many bed-hold days during this year were paid by Public Aid?
N/A (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒

I. On what date did you start providing long term care at this location?
Date started 05/25/26

J. Was the facility purchased or leased after January 1, 1978?
YES ☐ Date _____ NO ☒

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 15 and days of care provided 1,493

Medicare Intermediary AdminaStar Federal, Inc.

IV. ACCOUNTING BASIS

ACCUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 06/30/02 Fiscal Year: 06/30/02
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number WASHINGTON AND JANE SMITH # 0015032 Report Period Beginning: 07/01/01 Ending: 06/30/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	462,738	1,970		464,708		464,708	(2,324)	462,384			1
2	Food Purchase		681,834		681,834		681,834	(917)	680,917			2
3	Housekeeping	249,616	47,639		297,255		297,255		297,255			3
4	Laundry	81,547	35,662		117,209		117,209		117,209			4
5	Heat and Other Utilities			260,703	260,703		260,703	(21,120)	239,583			5
6	Maintenance	255,266	14,108	215,225	484,599		484,599	(44,687)	439,912			6
7	Other (specify):*											7
8	TOTAL General Services	1,049,167	781,213	475,928	2,306,308		2,306,308	(69,048)	2,237,260			8
	B. Health Care and Programs											
9	Medical Director			10,800	10,800		10,800		10,800			9
10	Nursing and Medical Records	2,366,473	95,188	81,522	2,543,183		2,543,183	(8,696)	2,534,487			10
10a	Therapy	71,132		12,277	83,409		83,409		83,409			10a
11	Activities	226,517	41,528	38,135	306,180		306,180		306,180			11
12	Social Services	183,408	2,009	2,768	188,185		188,185		188,185			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,847,530	138,725	145,502	3,131,757		3,131,757	(8,696)	3,123,061			16
	C. General Administration											
17	Administrative	198,876			198,876		198,876		198,876			17
18	Directors Fees											18
19	Professional Services			170,752	170,752		170,752	(54,079)	116,673			19
20	Dues, Fees, Subscriptions & Promotions			40,525	40,525		40,525	(6,147)	34,378			20
21	Clerical & General Office Expenses	242,488	58,731	7,469,119	7,770,338		7,770,338	(7,429,148)	341,190			21
22	Employee Benefits & Payroll Taxes			896,512	896,512		896,512		896,512			22
23	Inservice Training & Education											23
24	Travel and Seminar			11,168	11,168		11,168	(1,032)	10,136			24
25	Other Admin. Staff Transportation			1,104	1,104		1,104		1,104			25
26	Insurance-Prop.Liab.Malpractice			132,987	132,987		132,987		132,987			26
27	Other (specify):*											27
28	TOTAL General Administration	441,364	58,731	8,722,167	9,222,262		9,222,262	(7,490,406)	1,731,856			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,338,061	978,669	9,343,597	14,660,327		14,660,327	(7,568,150)	7,092,177			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,324)	1		4
5	Telephone, TV & Radio in Resident Rooms	(6,279)	6		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	14,397	30		9
10	Interest and Other Investment Income	(2,016)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(4,435)	21		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(264,792)	21		24
25	Fund Raising, Advertising and Promotional	(6,147)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(7,365,408)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (7,637,004)		\$	30

OHF USE ONLY							
48		49		50		51	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (7,637,004)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			499,183	499,183		499,183	6,805	505,988			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			205,977	205,977		205,977	(14,473)	191,504			32
33	Real Estate Taxes			3,412	3,412		3,412	(3,412)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			21,483	21,483		21,483		21,483			35
36	Other (specify):*			7,416	7,416		7,416		7,416			36
37	TOTAL Ownership			737,471	737,471		737,471	(11,080)	726,391			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		583,098	235,534	818,632		818,632		818,632			39
40	Barber and Beauty Shops			54,007	54,007		54,007		54,007			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			51,465	51,465		51,465		51,465			42
43	Other (specify):*	38,951		18,823	57,774		57,774	(57,774)				43
44	TOTAL Special Cost Centers	38,951	583,098	359,829	981,878		981,878	(57,774)	924,104			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	4,377,012	1,561,767	10,440,897	16,379,676		16,379,676	(7,637,004)	8,742,672			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

STATE OF ILLINOIS			Page 5A
WASHINGTON AND JANE SMITH			
ID# 0015032			
Report Period Beginning: 07/01/01			
Ending: 06/30/02			
NON-ALLOWABLE EXPENSES			Sch. V Line
			Amount Reference
1	NON SEMINAR EXPENSES	(1,032)	24 1
2	DEPRECIATION APT	(7,592)	20 2
3	APT. PROPERTY TAXES	(3,412)	23 3
4	PUBLIC RELATIONS EXP.	(138)	21 4
5	DEVELOPMENT COSTS	(247,500)	21 5
6	BLDG & GR APT - YARD MAINT	(420)	43 6
7	BLDG & GR APT - R&M EQUIP	(573)	43 7
8	BLDG & GR APT - R&M PAINT	(260)	43 8
9	BLDG & GR APT - PLUMBING	(275)	43 9
10	BLDG & GR APT - R&M BLDG	(1,358)	43 10
11	APT. INTEREST ON SECURITY DEPOSIT	(80)	43 11
12	BLDG & GR APT - REFUSE DISPOSAL	(1,730)	43 12
13	APT - HEAT POWER UTILITIES GAS	(3,317)	43 13
14	APT - HEAT POWER - ELECTRICITY	(1,793)	43 14
15	APT - HEAT POWER - WATER	(1,400)	43 15
16			16
17	INVEST ADVISORY FEE	(54,079)	19 17
18	MARKETING SALARY	(38,951)	43 18
19	BOND INTEREST - APT	(12,257)	22 19
20	LOC FEES - APT	(5,400)	43 20
21	MISC. BOND EXP. - APT	(3,362)	43 21
22	MISC. EXPENSES	(15,496)	21 22
23	MISC. DISPUTE WITH HEALTH INS.(OLD)	(7,780)	21 23
24	MISC. BOND EXP	(11,470)	21 24
25	UNREALIZED MV DECLINE - ENDOWMENT	(67,070)	21 25
26	UNREALIZED LOSS - GENERAL	(4,228,807)	21 26
27	REALIZED LOSS - GENERAL	(2,493,518)	21 27
28	DISCOUNT EARNED	(1,515)	21 28
29	RESIDENT TRANSPORTATION INCOME	(8,945)	06 29
30	MISC. RESIDENT CHARGES	(5,665)	21 30
31	GUEST ROOM INCOME	(917)	2 31
32	REFUNDS & REBATES	(3,317)	21 32
33	PODIATRY EXPENSE	(8,696)	10 33
34	CABLE TV	(21,120)	5 34
35			35
36	FLOWERS	(1,904)	21 36
37	FUNERAL EXP	(5,172)	21 37
38			38
39	LIFE CARE HEALTH INS.	(520)	21 39
40	LIFE CARE ALLOW.	(43)	21 40
41	R&M CAPITALIZED	(26,313)	6 41
42	PAINTING CAPITALIZED	(3,150)	6 42
43			43
44			44
45			45
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94			94
95			95
96			96
97			97
98			98
99			99
100			100
101	Total	(7,365,408)	101

Summary A

06/30/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]

Summary B

Facility Name & ID Number	WASHINGTON AND JANE SMITH	#	0015032	Report Period Beginning:	07/01/01	Ending:	06/30/02
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SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]

Facility Name & ID Number	WASHINGTON AND JANE SMITH	#	0015032	Report Period Beginning:	07/01/01	Ending:	06/30/02
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VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

[illegible]

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ **X** YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger		4	5 Cost to Related Organization		6	7	8 Difference:	
Schedule V			Line	Item	Amount	Name of Related Organization		Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	22	Insurance	\$ 9,381	The Orthon Group			\$ 9,381			1
2	V	26	Insurance	132,987	The Orthon Group			132,987			2
3	V	19	Investment	54,079	Heritage Capital			54,079			3
4	V										4
5	V										5
6	V										6
7	V										7
8	V										8
9	V										9
10	V										10
11	V										11
12	V										12
13	V										13
14	Total			\$ 196,447				\$ 196,447	\$ *		14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐

YES

☐

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐

YES

☐

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐

YES

☐

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐

YES

☐

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐

YES

☐

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	James J. Nemec	Board Member	President of the	None	None	10	25.00%	Financial	\$ 54,079	19-03	1
2			Board and owner					Services			2
3			of Heritage Cap.								3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 54,079		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WASHINGTON AND JANE SMITH # 0015032 Report Period Beginning: 07/01/01 Ending: 06/30/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization N/A

Street Address _____

City / State / Zip Code _____

Phone Number ()

Fax Number ()

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WASHINGTON AND JANE SMITH # 0015032 Report Period Beginning: 07/01/01 Ending: 06/30/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number
Fax Number

()

()

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WASHINGTON AND JANE SMITH # 0015032 Report Period Beginning: 07/01/01 Ending: 06/30/02

VIII. ALLOCATION OF INDIRECT COSTS

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3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WASHINGTON AND JANE SMITH # 0015032 Report Period Beginning: 07/01/01 Ending: 06/30/02

VIII. ALLOCATION OF INDIRECT COSTS

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	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
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2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WASHINGTON AND JANE SMITH # 0015032 Report Period Beginning: 07/01/01 Ending: 06/30/02

VIII. ALLOCATION OF INDIRECT COSTS

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	1	2	3	4	5	6	7	8	9	
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4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WASHINGTON AND JANE SMITH # 0015032 Report Period Beginning: 07/01/01 Ending: 06/30/02

VIII. ALLOCATION OF INDIRECT COSTS

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Street Address
City / State / Zip Code
Phone Number
Fax Number

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()

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
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2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WASHINGTON AND JANE SMITH # 0015032 Report Period Beginning: 07/01/01 Ending: 06/30/02

VIII. ALLOCATION OF INDIRECT COSTS

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B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
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	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
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8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WASHINGTON AND JANE SMITH # 0015032 Report Period Beginning: 07/01/01 Ending: 06/30/02

VIII. ALLOCATION OF INDIRECT COSTS

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B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number
Fax Number

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()

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
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7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WASHINGTON AND JANE SMITH # 0015032 Report Period Beginning: 07/01/01 Ending: 06/30/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number
Fax Number

()

()

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
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8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WASHINGTON AND JANE SMITH # 0015032 Report Period Beginning: 07/01/01 Ending: 06/30/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number
Fax Number

()

()

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
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2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

06/30/02

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Lasalle Bank		x	Building additon	Various	1991	\$ 5,800,000	\$ 5,800,000		2.70%	\$ 103,419	1
2	American Nat'l Bank		x	Building Apt			683,365	683,365		3.80%	12,456	2
3												3
4												4
5												5
	Working Capital											
6	Comerica		x	LOC							73,950	6
7												7
8												8
9	TOTAL Facility Related						\$ 6,483,365	\$ 6,483,365			\$ 189,825	9
	B. Non-Facility Related*											
10	See Supplemental Schedule										9,240	10
11	Unrealized loss-Eddy Trust										6,912	11
12	Invest. Income										(2,016)	12
13	Bond Interest Apt.										(12,457)	13
14	TOTAL Non-Facility Related						\$	\$			\$ 1,679	14
15	TOTALS (line 9+line14)						\$ 6,483,365	\$ 6,483,365			\$ 191,504	15

Line #

SEE ACCOUNTANTS' COMPILATION REPORT

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)**

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report.

\$	NA	1
----	----	---

\$	2
----	---

\$	3
----	---

\$	4
----	---

(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)

\$ 5

[illegible]

\$	6
----	---

\$	7
----	---

Real Estate Tax Bill for Calendar Year:

1997	8
1998	9
1999	10
2000	11
2001	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO:

Long Term Care Facilities with Real Estate Tax Rates

RE:

2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

WASHINGTON AND JANE SMITH

COUNTY

COOK

FACILITY IDPH LICENSE NUMBER

0015032

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ()

FAX #: ()

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.		\$	\$
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$	\$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home.
(Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

WASHINGTON AND JANE SMITH

COUNTY

COOK

FACILITY IDPH LICENSE NUMBER

0015032

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ()

FAX #: ()

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

(A)	(B)	(C)	(D)
			<u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to</u>
			<u>Nursing Home</u>
1.		\$	\$
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$	\$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 185,004 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 2

C. Does the Operating Entity? ☐ (a) Own the Facility ☒ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? ☐ (a) Own the Equipment ☒ (b) Rent equipment from a Related Organization. ☒ (c) Rent equipment from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1		247,516	Pre 1994	\$ 649,404	1
2					2
3	TOTALS	247,516		\$ 649,404	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	FOR OHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	40		1924		\$ 70,920	\$	40	\$	\$	\$ 70,920	4
5	57			1928	438,552		40			438,558	5
6	55			1958	429,080		35			429,080	6
7	50			1972	1,528,440	43,670	35	43,670		1,056,018	7
8	77			1992	4,868,578	139,102	35	139,102		1,391,021	8
	Improvement Type**										
9	Building Improvements			1972	307,827						9
10	Boiler and Ventilating			1974	48,223						10
11	Building Improvements			1975	91,428						11
12	Building Improvements			1978	205,755						12
13	Building Improvements			1980	102,046						13
14	Building Improvements			1981	31,819						14
15	Building Improvements			1982	53,600						15
16	Building Improvements			1983	163,759						16
17	Building Improvements			1984	187,160						17
18	Parking Lot			1984	3,580						18
19	Building Improvements			1985	26,309						19
20	Building Improvements			1987	149,405						20
21	Building Improvements			1989	81,658						21
22	Smith Wing Renovation			1989	150,364						22
23	Building Improvements			1991	160,090						23
24	Kitchen Remodeling			1991	931,139						24
25	Roof and Siding			1991	40,000						25
26	Building Improvements			1993	69,928						26
27	Fan Coil Project			1994	102,713						27
28	Building Remodeling			1995	52,983						28
29	Complete Fan Coil Project			1995	217,546						29
30											30
31											31
32	RECONCILIATION OF LIMPS DEPRECIATION					162,775		162,775			32
33	R&M 2001							1,114	1,114		33
34	R&M 2002							1,234	1,234		34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Roof	1996	\$ 14,045	\$		\$	\$	\$	37
38	Elevator	1996	28,857						38
39	Roof Repair	1997	118,147						39
40	Boiler Project	1997	96,589						40
41	Sidewalk Paving	1997	9,968						41
42	Gutter Replacement and Repairs	1997	3,886						42
43	Painting and Room Decorating	1997	24,159						43
44	Building Maintenance	1997	4,890						44
45	Window Repair and Replacement	1997	14,192						45
46	Heating and Plumbing	1992	7,248						46
47	Heating and Plumbing	1993	7,935						47
48	Heating and Plumbing	1995	5,575						48
49	Air Conditioner and Ventilating	1995	4,874						49
50	Telephone System	1996	22,211						50
51	Air Conditioner and Ventilating	1996	6,765						51
52	Security System	1997	14,872						52
53	Sprinkler System	1997	31,262						53
54	Air Conditioner and Ventilating	1997	28,183						54
55	Arts and Crafts Room Renovations	1998	9,232						55
56	Auditorium Renovations	1998	8,159						56
57	Boiler Project	1998	2,123						57
58	Elevator	1998	88,086						58
59	Heating and Plumbing	1998	7,259						59
60	Lighting Upgrade	1998	57,526						60
61	Phone System	1998	26,163						61
62	Roof Repair	1998	37,174						62
63									63
64									64
65									65
66									66
67									67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)								68
69	Financial Statement Depreciation								69
70	TOTAL (lines 4 thru 69)		\$ 11,192,282	\$ 345,547		\$ 347,895	\$ 2,348	\$ 3,385,597	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 11,237,269	\$ 345,547		\$ 347,895	\$ 2,348	\$ 3,385,597	1
2	Carpeting	10/1/2000	4,880						2
3	Vertical blinds	6/1/2001	1,211						3
4	Paint three floor corridors	4/1/2001	6,240						4
5	Paint kitchen	6/1/2001	3,535						5
6	Resident parking signs	8/1/2000	1,151						6
7	Plaster work	8/1/2000	4,152						7
8	Multi-purpose room	1999	8,834						8
9	Carpet in the front hallway	1999	7,756						9
10	AC Motor	1999	1,481						10
11	Elevator repair	1999	3,390						11
12	Asbestos encapsulation	6/1/2001	3,410						12
13	Replacement door	4/1/2001	1,019						13
14	Asphalt repair	5/1/2001	2,275						14
15	Tub supplies	6/1/2001	919						15
16	Tub supplies	6/1/2001	12						16
17	Renovations-2nd floor	10/1/2000	1,277						17
18	Renovations-2nd floor	11/1/2000	685						18
19	Renovations-2nd floor	6/1/2000	2,770						19
20	Renovations-2nd floor	1/1/2001	94						20
21	Renovations-2nd floor	3/1/2001	1,001						21
22	Tub supplies	6/1/2001	1,920						22
23	Renovations-2nd floor	2/1/2001	25,734						23
24	Tenant buildout	3/1/2001	3,903						24
25	Paint and patch hallways	11/1/2000	1,475						25
26	Floor covering	5/1/2001	1,050						26
27	Hydro-flushing of sewers	4/1/2001	785						27
28	Paint common areas	6/1/2001	429						28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 11,328,657	\$ 345,547		\$ 347,895	\$ 2,348	\$ 3,385,597	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 11,192,282	\$ 345,547		\$ 347,895	\$ 2,348	\$ 3,385,597	1
2	Smoke Detectors	1998	6,312						2
3	Kitchen Remodeling	1998	6,413						3
4	Air Conditioner and Ventilating	1998	2,815						4
5	Air Conditioner and Ventilating	1998	2,687						5
6	Electrical Fixtures for Hallways	1998	1,106						6
7	Head Rails for Hallways	1998	1,494						7
8	Refrigerator - R&M	5/22/2000	2,075						8
9	Refrigeration/freezer R&M	6/21/2000	1,428						9
10	Refrigeration/freezer R&M	7/17/2000	865						10
11	Carpeting - R&M	12/18/2000	832						11
12	Carpeting - R&M	12/6/2000	572						12
13	Shade-R&M	10/25/2000	813						13
14	Carpeting - R&M	8/4/2000	685						14
15	Plumbing - R&M	11/17/2000	1,075						15
16	Painting-main dining room R&M	8/18/2000	2,175						16
17	Paint - R&M	7/31/2000	584						17
18	Paint - R&M	7/26/2000	518						18
19	Irrigation system - R&M	5/22/2001	665						19
20	Paint - R&M	2/7/2001	587						20
21	Paint - R&M	3/22/2001	1,151						21
22	Boiler - R&M	2/20/2001	704						22
23	Shade - R&M	1/15/2001	1,037						23
24	Carpeting - R&M	4/6/2001	3,759						24
25	Air conditioning chiller R&M	6/4/2001	1,952						25
26	Thermostat R&M	1/4/2001	783						26
27	Waterproofing	6/1/2001	1,900						27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 11,237,269	\$ 345,547		\$ 347,895	\$ 2,348	\$ 3,385,597	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 11,328,657	\$ 345,547		\$ 347,895	\$ 2,348	\$ 3,385,597	1
2	Roof boiler house and Smith	9/1/2000	9,800						2
3	Tuckpoint building	10/1/2000	32,440						3
4	Caulking-wing walls, elevators	10/1/2000	4,580						4
5	Renovations-2nd floor Beverly	2/1/2001	384						5
6	Pre-construction Beverly	5/1/2001	667						6
7	Campus master Beverly	12/1/2000	5,335						7
8	Renovation-2nd floor Beverly	12/1/2000	1,751						8
9	Renovation-2nd floor Beverly	9/1/2000	1,647						9
10	Renovation-2nd floor Beverly	12/1/2000	1,939						10
11	Building improvements	12/1/2000	5,000						11
12	Carpet	1/1/2001	4,541						12
13	Carpet	1/1/2001	4,419						13
14	Security camera	6/1/2001	1,836						14
15	Fireproof file safe	5/1/2001	8,119						15
16	Smoke detectors	10/1/2000	2,458						16
17									17
18	Smoke detectors	7/1/2001	7,791						18
19	Certification letter for smoke detectors	8/1/2001	900						19
20	Sealcoat & Parking Lot	8/1/2001	3,125						20
21	Sewer Improvements	9/1/2001	2,434						21
22	Sewer Improvements	9/1/2001	200						22
23	Topography	10/1/2001	2,850						23
24	Tunnel Roofing	10/1/2001	2,800						24
25	Kitchen door replaclement	11/1/2001	2,350						25
26	Painting Hallway & Nursing Station	11/1/2001	5,544						26
27	Awning for Gregg Entrance	11/1/2001	776						27
28	Window Blinds	12/1/2001	3,327						28
29	Storm Damage Repair - Roof & Gutters	3/1/2002	28,675						29
30	Paint	4/1/2001	2,090						30
31	Air Conditioner	5/1/2001	298						31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 11,476,733	\$ 345,547		\$ 347,895	\$ 2,348	\$ 3,385,597	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 11,476,733	\$ 345,547		\$ 347,895	\$ 2,348	\$ 3,385,597	1
2	115 V Pump	5/1/2002	1,009						2
3	Landscape	5/1/2002	2,310						3
4	Upgrade Fire Safety System	5/1/2002	1,645						4
5	Painting	5/1/2002	12,635						5
6	Water Heater	5/1/2001	4,026						6
7	Upgrade Kitchen Wiring for Dishwasher	6/1/2002	7,850						7
8	Painting & Wall Removal	5/1/2002	9,460						8
9	Paint	5/1/2002	809						9
10	Generator Fuel Tank & Pump	6/1/2002	1,500						10
11	Refurbish Oakley Booster Pump	6/1/2002	1,401						11
12	Paint Stairwells	6/1/2002	982						12
13									13
14	AL Living Room	9/1/2002	283						14
15	AL Living Room	9/1/2002	2,274						15
16	AL Living Room - Electrical	9/1/2002	1,165						16
17	AL Living Room	9/1/2002	5,479						17
18	AL Living Room - Paint	10/1/2002	741						18
19	AL Living Room - Countertops	10/1/2002	3,065						19
20									20
21	Laundry AC Unit	4/2/2002	1,384	277		277			21
22	Common Area Carpet	5/1/2002	1,755	351		351			22
23	Guardian System Additions	5/1/2002	5,915	592		592			23
24	Painting - R&M	5/1/2002	3,150			158	158		24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 11,545,571	\$ 346,767		\$ 349,273	\$ 2,506	\$ 3,385,597	34

SEE ACCOUNTANTS' COMPILATION REPORT

****Improvement type must be detailed in order for the cost report to be considered complete.**

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 11,545,571	\$ 346,767		\$ 349,273	\$ 2,506	\$ 3,385,597	1
2	Filters	9/14/2001	828						2
3	Generator Repair	9/30/2001	775						3
4	Security Key Pad	10/17/2001	1,111						4
5	Cabling Material & Labor	10/23/2001	3,973						5
6	Painting	10/25/2001	2,396						6
7	Sewage Pump	4/30/2002	720						7
8	Flag Pole	7/31/2002	644						8
9	Carpeting	8/31/2001	7,063						9
10	Window Shades	8/31/2001	1,370						10
11	Window Treatment	11/19/2001	576						11
12	Doors	12/18/2001	1,685						12
13	AL Dining Room Remodeling	12/18/2001	847						13
14	Gas Valve Operator	12/18/2001	1,383						14
15	Valves & Operator	1/31/2002	1,299						15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 11,570,241	\$ 346,767		\$ 349,273	\$ 2,506	\$ 3,385,597	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 11,570,241	\$ 346,767		\$ 349,273	\$ 2,506	\$ 3,385,597	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 11,570,241	\$ 346,767		\$ 349,273	\$ 2,506	\$ 3,385,597	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$11,570,241	\$346,767		\$349,273	\$2,506	\$3,385,597	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$11,570,241	\$346,767		\$349,273	\$2,506	\$3,385,597	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$11,570,241	\$346,767		\$349,273	\$2,506	\$3,385,597	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$11,570,241	\$346,767		\$349,273	\$2,506	\$3,385,597	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4					\$	\$		\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$	\$		\$	\$	\$	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$802,718	\$69,068	\$80,795	\$11,727	10	\$	71
72	Current Year Purchases	69,849	7,448	7,612	164	10		72
73	Fully Depreciated Assets	619,547	61,955	61,955		10		73
74								74
75	TOTALS	\$1,492,114	\$138,471	\$150,362	\$11,891		\$	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Nursing Facility	1999 Ford Taurus	1999	\$16,118	\$2,303	\$2,303	\$	7	\$	76
77	Nursing Facility	1987 Ford F250 Pick up	1998	7,300	1,043	1,043		7		77
78	Nursing Facility	2000 Ford Goshen Bus	2000	45,104	3,007	3,007		7		78
79										79
80	TOTALS			\$68,522	\$6,353	\$6,353	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$13,780,281	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$491,591	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$505,988	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$14,397	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$3,385,597	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Land Apt	\$112,500	\$	\$	86
87	Building Apt	487,975	12,199	67,096	87
88	Building Improv. Apt	112,576	(9,005)	40,945	88
89	Furniture Apt	29,278	4,398	20,841	89
90					90
91	TOTALS	\$742,329	\$7,592	\$128,882	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease.

9. Option to Buy:
- ☐ YES☐ NO
- Terms:
- *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?
☐ YES☐ NO
16. Rental Amount for movable equipment: \$21,483
- Description: Copier \$11,355 - Computer Software \$10,128
- (Attach a schedule detailing the breakdown of movable equipment)

10. Effective dates of current rental agreement:
Beginning
Ending
11. Rent to be paid in future years under the current rental agreement:
- Fiscal Year EndingAnnual Rent
12. /2003\$
13. /2004\$
14. /2005\$

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER AIDE

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER AIDE

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

12345678										
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 103,202	\$		\$ 103,202	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			7,350			7,350	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			124,982			124,982	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescripts				480,078		480,078	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental						103,020		103,020	13
14	TOTAL			\$		\$ 235,534	\$ 583,098		\$ 818,632	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 368,053	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,328,365		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	22,365		6
7	Other Prepaid Expenses	11,148		7
8	Accounts Receivable (owners or related parties)	8,887,787		8
9	Other(specify): See Supplemental Schedule	1,279		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 10,618,997	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	47,373,471		12
13	Land	761,904		13
14	Buildings, at Historical Cost	7,823,545		14
15	Leasehold Improvements, at Historical Cost	2,951,814		15
16	Equipment, at Historical Cost	2,414,712		16
17	Accumulated Depreciation (book methods)	(6,530,922)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Supplemental Schedule	390,492		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 55,185,016	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 65,804,013	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 183,921	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	10,710		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	270,723		30
31	Accrued Taxes Payable (excluding real estate taxes)	(1,038)		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Supplemental Schedule	120,436		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 584,752	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	6,483,365		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Supplemental Schedule			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 6,483,365	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 7,068,117	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 58,735,896	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 65,804,013	\$	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 62,230,694	1
2	Restatements (describe):		2
3	PY was consolidated FS	(153,302)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 62,077,392	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(3,341,496)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (3,341,496)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 58,735,896	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	Amount	1
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 7,533,841	1
2	Discounts and Allowances for all Levels	(1,315,165)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,218,676	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	405,591	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 405,591	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	53,586	13
14	Non-Patient Meals	2,324	14
15	Telephone, Television and Radio	6,279	15
16	Rental of Facility Space		16
17	Sale of Drugs	553,349	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	274,135	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 889,673	23
	D. Non-Operating Revenue		
24	Contributions	2,844,268	24
25	Interest and Other Investment Income***	2,539,273	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 5,383,541	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	140,699	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 140,699	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 13,038,180	30

	Expenses	Amount	2
	A. Operating Expenses		
31	General Services	2,306,308	31
32	Health Care	3,131,757	32
33	General Administration	9,222,262	33
	B. Capital Expense		
34	Ownership	737,471	34
	C. Ancillary Expense		
35	Special Cost Centers	930,413	35
36	Provider Participation Fee	51,465	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 16,379,676	40
41	Income before Income Taxes (line 30 minus line 40)**	(3,341,496)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (3,341,496)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number WASHINGTON AND JANE SMITH

0015032

Report Period Beginning:

07/01/01

Ending:

06/30/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,681	1,950	\$ 67,285	\$ 34.51	1
2	Assistant Director of Nursing	1,646	1,950	42,357	21.72	2
3	Registered Nurses	29,369	31,346	587,417	18.74	3
4	Licensed Practical Nurses	24,388	26,165	393,652	15.04	4
5	Nurse Aides & Orderlies	94,052	96,939	1,256,081	12.96	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,246	5,954	71,132	11.95	8
9	Activity Director	1,943	1,961	30,593	15.60	9
10	Activity Assistants	22,523	23,587	195,924	8.31	10
11	Social Service Workers	7,476	7,734	183,408	23.71	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	7,061	7,910	105,571	13.35	14
15	Cook Helpers/Assistants	29,997	31,448	251,345	7.99	15
16	Dishwashers	13,149	13,713	105,822	7.72	16
17	Maintenance Workers	21,528	23,662	255,266	10.79	17
18	Housekeepers	17,304	18,967	249,616	13.16	18
19	Laundry	8,511	9,517	81,547	8.57	19
20	Administrator	1,770	1,950	100,797	51.69	20
21	Assistant Administrator	1,935	1,950	84,300	43.23	21
22	Other Administrative	675	698	13,779	19.74	22
23	Office Manager	1,898	1,950	60,285	30.92	23
24	Clerical	12,599	15,439	182,203	11.80	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,417	1,711	19,681	11.50	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	1,845	1,950	38,951	19.97	33
34	TOTAL (lines 1 - 33)	308,013	328,451	\$ 4,377,012 *	\$ 13.33	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director	Monthly	10,800	09-03	36
37	Medical Records Consultant	Monthly	4,080	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	246	12,277	10a-03	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	48	2,484	11-03	44
45	Social Service Consultant	19	1,039	12-03	45
46	Other(specify)				46
47	Chaplain	52	1,729	12-03	47
48	Physical Fitness Program	1,621	35,651	11-03	48
49	TOTAL (lines 35 - 48)	1,986	\$ 68,060		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	154	\$ 7,942	10-03	50
51	Licensed Practical Nurses	1,970	69,500	10-03	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	2,124	\$ 77,442		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number		WASHINGTON AND JANE SMITH		STATE OF ILLINOIS				Page 23
		#	0015032	Report Period Beginning:	07/01/01	Ending:	06/30/02	

XX. GENERAL INFORMATION:

(1)

Are nursing employees (RN,LPN,NA) represented by a union?

NO

(2)

Are there any dues to nursing home associations included on the cost report?
If YES, give association name and amount.

YES
LSN - \$23,938

(3)

Did the nursing home make political contributions or payments to a political action organization?
If YES, have these costs been properly adjusted out of the cost report?

NO

(4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?
If YES, what is the capacity?

NO

(5)

Have you properly capitalized all major repairs and equipment purchases?
What was the average life used for new equipment added during this period?

YES
10

(6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$ 55,890 Line 10

(7)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?
If NO, attach a complete explanation.

YES

(8)

Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease.

NO

(9)

Are you presently operating under a sublease agreement?

YES X NO

(10)

Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?
If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

YES NO X

(11)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period.
This amount is to be recorded on line 42 of Schedule V.

\$ 51,465

(12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?
If YES, attach an explanation of the allocation.

NO

(13)

Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?

YES

(14)

Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?
For example, is a portion of the building used for rental, a pharmacy, day care, etc.)
If YES, attach a schedule which explains how all related costs were allocated to these functions.

NO

(15)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.
Has any meal income been offset against related costs?
Indicate the amount.

\$ NO

(16)

Travel and Transportation

a.

Are there costs included for out-of-state travel?
If YES, attach a complete explanation.

NO

b.

Do you have a separate contract with the Department to provide medical transportation for residents?
If YES, please indicate the amount of income earned from such a program during this reporting period.

NO

c.

What percent of all travel expense relates to transportation of nurses and patients?

N/A

d.

Have vehicle usage logs been maintained?

NO

e.

Are all vehicles stored at the nursing home during the night and all other times when not in use?

YES

f.

Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

N/A

g.

Does the facility transport residents to and from day training?
Indicate the amount of income earned from providing such transportation during this reporting period.

NO
\$ N/A

(17)

Has an audit been performed by an independent certified public accounting firm?
Firm Name:
The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached?
If no, please explain.

FR&R

(18)

Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?

YES

(19)

If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report?
Attach invoices and a summary of services for all architect and appraisal fees

YES

SEE ACCOUNTANTS' COMPILATION REPORT